

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/11/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
--------------------------------------------------------------------------------	---------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was a fundamental recertification and state licensure survey. This visit included the investigation of complaint #IN00105640.</p> <p>Complaint #IN00105640-UNSUBSTANTIATED, due to lack of evidence.</p> <p>Dates of Survey: April 9, 10, and 11, 2012</p> <p>Facility number: 011602 Provider number: 15G748 AIM number: 200903760</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/20/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #2) to ensure his Comprehensive Functional Assessment (CFA) was completed.</p> <p>Findings include:</p> <p>On 4-10-12 at 9:30 a.m. a record review for client #2 was conducted. The review indicated client #2 had no Comprehensive Functional Assessment available for review.</p> <p>On 4-10-12 at 10:15 a.m. an interview with the Director of Operations indicated there was no CFA available to review for client #2 but only a blank one in his file.</p> <p>9-3-4(a)</p>	W0210	<p>Functional Assessments were completed for Client 2 to reflect current functional status. Functional assessments will be completed within 30 days of admission, those findings will be incorporated into the ISP. QDDP will be responsible for completing the assessment and updating annually. QDDP and Director of Operations will be responsible for ensuring the presence of a CFA and its completion.</p>	04/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview, the facility failed to assess the vocational skills of 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 4-10-12 at 8:45 a.m. The review indicated the client's vocational skills had not been assessed.</p> <p>On 4-9-12 at 12:30 p.m. an interview with client #1 was conducted. Client #1 indicated he wanted to go to work so he could make more money to purchase items because he could not live on \$52.00 a month.</p> <p>On 4-10-12 at 10:15 a.m. an interview with the Director of Operations (DO) indicated client #1's admission date was 10-8-10 and client #1 did not have a vocational assessment available for review. The DO indicated client #1 was not employed but he did participate in a home based day program.</p> <p>9-3-4(a)</p>	W0225	<p>A vocational Assessment was completed to assess vocational needs. A vocational assessment will be completed within 30 days of admission and updated annually by QDDP. QDDP and Director of Operations will be responsible for ensuring the presence and completeness of said assessment. We have recently been informed by Vocational Rehabilitation that clients are unable to have an open case, in their current setting, due to receiving 24 hour staff support - VR feels that if a Client has to receive 24 hour staff support, they are not ready for community employment. If a Client has a desire to work and make money team has assisted with filling out applications to desired work places and also referred clients to day programs with paid vocational type of work. Additionally Clients are encouraged to volunteer to build their work place skills.</p>	04/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 3 clients (clients #2 and #3) who lived in the home, to ensure their Individualized Support Plans (ISP) had a grooming objective to assist with proper nail care.</p> <p>Findings include:</p> <p>On 4-9-12 from 12:20 p.m. until 2:00 p.m. an observation at the home of client #3 was conducted. At 1:40 p.m. client #3's fingernail tips were 1/4 inch long and dark under the tips .</p> <p>On 4-10-12 from 6:40 a.m. until 8:35 a.m. an observation at the home of client #2 was conducted. At 7:15 a.m. during client #2's medication administration his fingernail tips were 1/4 inch long and dark under the tips.</p> <p>On 4-10-12 at 9:30 a.m. a record review for client #2 was conducted. The ISP dated 8-11 indicated client #2 had no goal/objective to address his nail care needs.</p>	W0227	Nail care was added to client 2 and 3's MAR to remind customers and staff to trim their nails. Hygene is part of a cleints daily routine. Hygene routines are established to work for the client - at their desire. 2 Clients do not wish to have a goal addressing nail hygene and wish to have a reminder placed on their Medicaiton Administration record. Hygene is assessed ongoing, goals are put in place to address deficiencies and goals are developed with the agreement of the client. QDDP, Nurse, and Director of Operations will be responsible for assessing completeness of needed hygene items.	04/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 4-10-12 at 10:10 a.m. a record review for client #3 was conducted. The ISP dated 8-11 indicated client #3 did not have a grooming objective to assist him with his nail care needs.</p> <p>On 4-10-12 at 10:15 a.m. an interview with the House Manager indicated clients #2 and #3 could use a grooming objective or a tracking method in the Medication Administration Record to assist them with their nail care skills.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based in observation, record review, and interview, the facility failed for 3 of 3 clients (clients #1, #2, and #3) who lived in the home to ensure they participated with meal preparation consistent with their developmental level.</p> <p>Findings include:</p> <p>On 4-9-12 from 12:20 p.m. until 2:00 p.m. an observation at the home of clients #1, #2, and #3 was conducted. At 12:55 p.m. client #1 washed his hands, opened two cans of soup, then poured the soup into a pan. Client #1 took the turkey from the refrigerator and placed in on the counter. Direct care staff (DCS) #2 got the wraps, lettuce, cheese and ranch dressing out of the refrigerator. At 1:05 p.m. DCS #2 placed a wrap and lettuce it the food processor. DCS #2 asked client #1 how much lettuce he would like; she placed lettuce and two wraps on client #1's plate. Client #1 sat on the couch. DCS #2 wrapped the lettuce in foil, dated it, and placed it back into the refrigerator. DCS#2 added the lunch meat to the wrap and lettuce in the food processor. DCS #2 used scissors to open the cheese packet, stirred the soup, then added</p>	W0488	Staff were retrained on active treatment in regards to meal preparation to include and prompt clients in assisting with meal preparation. QDDP and Director of Operations have incorporated ongoing training when visiting group homes. Staff have been given tools on looking at ways to keep clients involved in their daily routines. This will be evaluated by site visits - planned and unplanned.	04/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012	
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>cheese to the wrap, lettuce, and meat in the food processor. DCS #2 added ranch dressing to the food processor. Client #1 stood in the kitchen and client #3 was in the bathroom. At 1:15 p.m. DCS #2 used the food processor to mix the wrap, lettuce, cheese, meat, and ranch together. DCS #2 cleaned out the food processor, took cans of fruit from the cupboard then asked client #1 to open the cans of fruit. DCS #2 got a bowl from the cabinet for client #1 to pour the fruit into. Client #1 put the cans in the trash and poured the cans of fruit into the bowl independently. DCS #3 took a bowl and a serving spoon from the drawer and cabinet, put fruit in the food processor and mixed it. DCS #2 added a thickening agent to the fruit from the food processor. At 1:25 p.m. client #1 sat at the dining room table, client #2 talked with staff about his money, and client #3 was talking with staff in the office. DCS #2 poured the pureed fruit into a bowl, rinsed out the processor, and stirred the soup. Client #3 came to the kitchen and asked if his lunch was done. DCS #2 indicated she was making it as quick as she could. DCS #2 stirred the soup, took a serving bowl out and poured the soup into the bowl. Client #1 sat at the table and client #3 watched DCS #2 prepare the soup. DCS #2 carried client #3's prepared plate and bowl of fruit to the table as client #3 followed her. DCS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#2 placed the meat into a bowl, threw away the meat container, carried the bowl of cheese and the bowl of meat to the table. DCS #2 placed a wrap on a plate and placed it in the microwave. At 1:35 p.m. DCS #2 placed napkins and silverware on the table. Client #3 asked DCS #2 to get him a drink. DCS #2 poured a cup of milk, added a thickening agent, stirred the milk, then took him his prepared drink. DCS #2 took the ranch dressing, bowl of fruit, and individual bowls to the table. DCS #2 took the wrap from the microwave and placed it on client #2's plate.</p> <p>On 4-9-12 from 4:20 p.m. until 6:00 p.m. an observation at the home of client #3 was conducted. At 5:40 p.m. DCS #5 placed vegetables in the food processor, placed rice in the food processor, and then she took the food from the processor and placed it on the plate for client #3. At 5:50 p.m. DCS #4 rinsed the food processor, placed the chicken in the processor, pureed the chicken, then placed the chicken on the plate for client #3. Client #3 sat in a chair watching television while DCS #4 and #5 prepared his food for him.</p> <p>On 4-10-12 at 8:45 a.m. a record review for client #1 was conducted. The Comprehensive Functional Assessment</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/11/2012
NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 8-1-11 indicated client #1 was able to assist with meal preparation independently.</p> <p>On 4-10-12 at 9:30 a.m. a record review for client #2 was conducted. The Comprehensive Functional Assessment was incomplete with no information available for review</p> <p>On 4-10-12 at 9:45 a.m. a record review for client #3 was conducted. The Comprehensive Functional Assessment dated 8-1-11 indicated client #3 was able to assist with meal preparation with assistance.</p> <p>On 4-10-12 at 10:15 a.m. an interview with the House Manager indicated clients #1, #2, and #3 should have assisted with meal preparation and they were all capable of assisting with meal preparation.</p> <p>9-3-8(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/11/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
--------------------------------------------------------------------------------	---------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE